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# The Effect of Clinician Competence and Religiosity on the Trainee Clinician's Ability to Identify Problematic Sexual Behavior

Cody Butcher

*Minnesota State University, Mankato*

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The Effect of Clinician Competence and Religiosity on the Trainee Clinician's Ability to Identify  
Problematic Sexual Behavior

A Thesis Submitted To The Faculty Of Minnesota State University, Mankato

By

Cody Michael Butcher

In Partial Fulfillment Of The Requirements For The Degree Of Masters Of Arts in  
Clinical Psychology

Supervisor: Dr. Eric Sprankle, Assistant Professor

May, 2017

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The Effect of Clinician Competence and Religiosity on the Trainee Clinician's Ability to  
Identify Problematic Sexual Behavior

Cody Butcher

This thesis has been examined and approved by the following members of the student's  
committee.

Eric Sprankle

Advisor

Kristie Campana

Committee Member

Jeffrey Buchanan

Committee Member

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### Dedication

Many people have helped me get to the point where I am today. First and foremost, I would like to dedicate this manuscript to my loving, warm, patient, and ever supporting wife, Ashley. Since we first met, Ashley, you have always provided me with the support and encouragement to go after my goals. You not only center me in times of distress, but you have a great ability to keep me humble. I look forward to what the path of our life will look like.

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# Abstract

Models in psychology do not consider the concept of *sex addiction* the same way as other substance or behavior addictions. For example, sex addiction, which is not a *DSM-5* disorder, is often assigned as a label to clients based off of high frequency of sexual behavior. Despite sex addiction not being a diagnosable disorder, sex addiction therapists are conducting treatment with people who identify as *sex addicts*. Due to this lack of a definition, previous research has found that clinicians may identify sex addiction in clients based on their own preconceived worldviews of what types of sexual behaviors or frequencies are deemed pathological. These worldviews are typically tied into values. Arguably, the largest quality that impacts a persons' values is religiosity. Therefore there is a possibility that religiosity impacts clinical decision making regarding sexual behaviors. Thirty-eight trainee clinicians were presented with one of two vignettes. Both vignettes reported a client who had high frequency of sexual behaviors and engaged in unconventional sex acts (e.g., BDSM). Yet, only one vignette reported significant clinical distress related to the behaviors. Trainee clinicians answered various measures of psychopathology regarding the person in the vignette. Results showed that trainee clinicians reported similar ratings of pathology between the two vignettes. Religiosity was examined in an exploratory manner due to lack of participants. These exploratory analyses showed that religiosity had no effect on how trainee clinicians scored.

*Key words:* Sex addiction, religiosity motivations, stigma, behavior, clinician competence, trainee clinicians

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## Introduction

### The Definition of Sex Addiction Through the Years

*Sex addiction* is a concept and definition that has changed throughout history. Due to this shifting, the ‘diagnosis’ and treatment of actual sex addictiveness has not been properly assessed or studied as it has never actually been defined (Irvine, 1998). Initially in the 19<sup>th</sup> century, sexual acts that caused cultural anxiety and were relatively taboo compared to societal norms were labeled *perversion* (Irvine, 1998). In the 1970s and 1980s, the term *perversion* morphed and was reinvented into sex addiction, which consisted of perceived, out of the ordinary, and out of control sexual behavior (Irvine, 1998; Raey, Atwood, & Gooder, 2013). However, out of control sexual behavior was previously measured by considering the frequency and type of sexual behavior, rather than the relationship to the behavior. This refers to whether the behavior is inhibiting or distressing in some way, and is a major consideration in other addiction models.

Reay et al. (2013) found that the cultural context of sex addiction finds that what ever is considered ‘sexually addictive’ at the time is a response to cultural anxieties. Sex addiction themes have consistently shifted. Initially, they focused on discourse in excess of control based on frequency. This idea continues today, while also considering sexual behaviors that are very broad and ill-defined, such as engaging in cyber sex (Edwards, Delmonico, & Griffen, 2011; Laurance, 2008). People who participate in these behaviors that are considered taboo by traditional society are given the label *sex addict* without considering the person’s relationship to the behavior. The relationship to the behavior refers to the amount of time, energy, or value a person places on a behavior, and this relationship needs to be distressing or impairing to the persons’ life in order to be considered pathological.

To give weight to the concept that sex addiction has no clinical definition, consider that some mental health professionals who work in sexual health have stated that sex addiction can consist of “too much sexual behavior with a committed, consenting partner” or even without sexual behavior at all, a term labeled *sex anorexia* (Edwards et al., 2011). These two behaviors are strictly counter-intuitive, yet can somehow represent the same disorder. The label of addict should never be assigned to a client lightly. Once this label has been given to an individual, many negative stigmatizing qualities are assumed (Sanders, 2012).

In support of the idea that the definition of sex addiction changes based on the cultural anxieties rather than an actual diagnosable behavior, we can consider the *Handbook of Clinical Sexuality for Mental Health Providers* (Levine, Risen, & Althof, 2003). This handbook, given to professionals in the sexual health field, claims that “sexual compulsivity seems more prevalent now than ever. Although, we have no good data of the prevalence of such problems, they appear to be escalating at an alarming rate, possibly due to the internet” (pg. 313). The authors create an argument that sex addiction (compulsivity) is on the rise, with no evidence to support this idea. Consider further McCall’s (2011) article where he stated that “sex addiction is the tsunami of mental health,” and then goes on to provide no evidence-based support to back up this claim.

## **Literature Review**

### **Sex addiction vs. other addiction disorders**

Many criteria are presented in the *DSM-5* for substance use disorders and behavioral addictions (American Psychiatric Association, 2013). Nearly all of the mandatory criteria for use disorders begin with criterion A, stating “A problematic pattern of (substance) use leading to clinically significant impairment or distress, as manifested by at least two of the following...” (DSM-5, 2013). Even when considering behavioral addictions such as gambling disorder, which

is a better approximate for sex addiction, the same criterion is set as well. If the psychology field considers the distress and impairment of the individual as a major criterion for other addiction disorders, shouldn't it consider *sex addiction* in the same way? The authors of this paper, among other professionals, would argue yes.

Also, consider the positive statement on sex addiction put out by the American Association of Sexuality Educators, Counselors, and Therapists (AASECT),

“AASECT recognizes that people may experience significant physical, psychological, spiritual and sexual health consequences related to their sexual urges, thoughts or behaviors. AASECT recommends that its members utilize models that do not unduly pathologize consensual sexual behaviors. AASECT 1) does not find sufficient empirical evidence to support the classification of sex addiction or porn addiction as a mental health disorder, and 2) does not find the sexual addiction training and treatment methods and educational pedagogies to be adequately informed by accurate human sexuality knowledge. Therefore, it is the position of AASECT that linking problems related to sexual urges, thoughts or behaviors to a porn/sexual addiction process cannot be advanced by AASECT as a standard of practice for sexuality education delivery, counseling or therapy (AASECT Position on Sex Addiction, 2016).”

This idea is consistent with other models of addiction where the relationship to the behavior is considered, rather than the behavior itself.

Although the initial acquirement of the label “sex addict” may not cause immediate harm, referments are made to sex addiction therapists consistently. Many treatments for sex addictions have little evidence to support their effectiveness, and some of these treatments can last 5-8 years, well past timelines for other known disorders (Carnes, 1989; Phillips, 2006).

### **The impact of values and the lack of definition for *sex addiction***

The problem with these loosely agreed upon definitions for sex addiction can lead therapists' characteristics, values, and worldviews to have a massively biasing effect on their diagnosis of problematic sexual behaviors, as evidence shows these variables impact the diagnosis of other actual defined disorders (Beutler & Bergan, 1991; Strupp, 1980).

Clinical psychologists are not free from decision making errors due to bias or other confounding factors when diagnosing. Becker and Lamb (1994) found that clinicians had decision errors based on the clinicians' own gender, and based on the gender of the client. Two identical vignettes presenting equal borderline personality disorder (BPD) and post-traumatic stress disorder (PTSD) symptoms were provided with the gender of the client modified. Results indicated that women patients were significantly more likely to be diagnosed with BPD regardless of clinician gender, and women clinicians were more likely to diagnose PTSD regardless of the gender of the client.

Other studies have found that the health status and age of the client (James & Haley, 1995) and clinician theory orientation (Woodward, Taft, Gordon, & Meis, 2009) both significantly impacted a clinician's ability to make an accurate diagnosis based on a vignette. Many of these misdiagnoses come from the use of heuristic and implicit biases that clinicians are not immune to. Clinicians can be influenced to begin homing in on one specific disorder after hearing a symptom or demographic characteristic that they correlated with a specific illness. For example, a study found that the order of the presented symptoms in a vignette impacted the diagnosis of bipolar disorder, rather than the overall picture of how many symptoms were actually present (Wolkenstein, Bruchmuller, Schmid, & Meyer, 2011). A recent systematic review on the effect of implicit racial/ethnic bias held by health care professionals found that there were significant negative relationships with patient-provider interactions, treatment adherence, treatment decisions, and patient health outcomes based on implicit racial/ethnic bias (Hall, et al., 2015).

As evidenced above, the influence of clinician characteristics, values, and worldview on their assessment and diagnosis of specifically outlined DSM disorders is undeniable. However,

relatively little research exists that examines the effect of clinicians' characteristics, worldviews and values on the pathologizing of sexual addictive type behaviors. This research is especially necessary due to the stigmatizing nature and vagueness in the definition of sex addiction.

In order to examine how specific worldviews might impact a clinician's ability to label sexual behaviors, Hacker, Trepper, Wetchler and Fontaine (1995) examined how different therapists' values would influence their assessment of sexual addiction. The values examined included sex outside of marriage, gender stereotypes regarding sexual activities, sex of the clinician, and religiosity of the clinician. Participants were clinical members of the American Association for Marriage and Family Therapy. Four vignettes for patients were created with the gender and marital statuses modified in each. In an objective manner, none of the behaviors described in the vignettes were actually addictive. All acts were consensual, non-inhibiting, and safe sex was practiced. Additionally, religiosity and the gender of the respondent were examined as independent variables. Dependent variables included measures of sexual pathology, degree that the client is a sex addict, and a question assessing the type of therapy session that the client needed.

Main effects were found for clinician gender, client (vignette) marital status, and clinician religiosity. Male clinicians rated the client as more sexually addicted than female clinicians, and all single clients were rated as more pathological compared to their married counterparts. In line with the stigma of high frequency sex behaviors, one clinician even wrote in the open ended section "Simply put, Richard (Single man) needs to grow up, face his adolescent fixation, and decide to choose to discipline himself. He is a good example of today's me first mind set" (pg. 269).

Clinicians who responded high in religiosity rated all clients as more pathological compared to those low in religiosity, although this difference was rather small. A major limitation that only can be assessed now is that they used a more basic form of measuring religiosity compared to the current religious motivation method of examining religiosity. Current measures of religiosity focus on the motivation for practicing the religion rather than previous measures which considered just the amount of church attended. These motivations have been shown to be correlated with many different social constructs.

### **The effect of religiosity on various social constructs**

Modern study of religiosity has found that religious motivations are a major influence on the values and worldviews that a person holds, as well as the cognitive processes that people engage in. This includes stigma, prejudice, and identifying one as part of an in-group or out-group member (Allport & Ross, 1967; Batson & Ventis, 1982; Genia, 1996; Hood et. al, 2005; Johnson, Rowatt, & Labouff, 2012). There are four main religious motivations that are thought to form the basis of religiosity. These include intrinsic, extrinsic, quest, and religious fundamentalist motivations.

### ***Religiosity motivation types***

Intrinsic religiosity was first considered by Allport and Ross (1967). People who are high in intrinsic religiosity internalize their religion to the fullest degree. People high in intrinsic religiosity frequently refer back to their religious text or belief structure when challenged with new information, and then adhere to the religion for no extrinsic value other than the happiness it gives them. Intrinsic religious motivations positively correlate with many aspects including social desirability, and depending on the religion belief structure, prejudice and discrimination are levels lower/higher. It also negatively correlates with depression levels (Genia, 1996).



Extrinsic religiosity was also considered by Allport and Ross (1967). Extrinsic religiosity is the exact opposite of intrinsic. Where as intrinsic motivations make a person live their religion, extrinsic motivations and individuals use their religion for some sort of gain. They do this for a variety of reasons including social status gain, distractions, or self-justifications, and they typically view religion as a means to an end rather than a part of themselves. Findings on individuals high in extrinsic religiosity when compared to intrinsic religiosity show that they are less socially desirable, have lower self-esteem, and are more prejudiced and discriminatory regardless of their religious orientation (Genia, 1996).

Quest religiosity is a motivation which views all religions as right and that religion is a lifelong journey. Those who are high in quest religiosity are motivated to practice their religion in an inclusive-to-all manner. They tend to view religion as a lifelong journey in which all people deserve love regardless of their own religious orientation, and they tend to be accepting of ambiguity or new experiences (Batson, 1976). Quest religiosity has been found to be positively correlated with lower levels of prejudice, as well as increased tolerance of differences (Batson & Ventis, 1982).

Religious fundamentalism is the newest consideration for religious motivations, although its roots are likely the oldest (Hood et al., 2005). Religious fundamentalism is the opposite of quest religiosity. People high in religious fundamentalism focus on literal interpretation of religious texts, dislike ambiguity, and adhere to rigid and inflexible values. They typically hold values or opinions that their religion is the only right religion, and that all other people who don't adhere to their strict values are flawed and wrong. Research shows that people high in religious fundamentalism are positively correlated with prejudice and hold rigid worldviews towards anyone not strictly adhering to the person's specific values (Watson et. al, 2003).

### **Mediation Effects**

Due to the evidenced ability for clinicians to let their bias, stigmatizing attitudes, and values affect their clinical decision making, and correlations between a person's religiosity to their values, stigma, and prejudice, it is within the realm of argument that religiosity could play a large role in the likelihood for a clinician to label a client's behavior as sexually addictive. This is especially true when considering the lack of a true clinical definition regarding sex addiction for the clinician to reference. It is these issues that the current study intends to examine.

### **Aims and Hypotheses of the Current Study**

Due to the aforementioned research and theories, the current study has a main hypothesis and one exploratory analysis to support future research. First, this study aims to examine how trainee clinicians label patients as showing sexual addiction based on vignettes where one has sexually addictive behaviors evidenced by lack of control and large reported distress and one does not. On this aim, we have 3 main hypotheses: 1) Trainee clinicians will assign similar levels of sexual pathology to both vignettes, 2) Trainee clinicians will assign similar levels of the sex addictiveness of the client to both vignettes, and 3) Trainee clinicians will assign similar levels of their likelihood to refer the client to a sex addiction therapist. That is, they will not be able to differentiate between the two vignettes because there is no agreed upon definition of sex addiction, and they will be imparting their own ideas into their diagnosis. The two vignettes will be rated similarly. Ideally, these vignettes should be rated differently. One has distress and is pathological, and the other doesn't and is therefore not pathological. Yet, because this sample comes from U.S. society which operates on a sex negative model of sex addiction, we hypothesize that the trainee clinicians will not be able to see past the high frequency behaviors and rate the non-distressed vignette as pathological as the other. Second, this study aims to

further expand previous research examining how the current models of religiosity motivation in trainee influences their rating of sexually pathology. In order to do this, an exploratory analysis of the relationship between religiosity measures and the pathology measures will be conducted. No hypotheses about these relationships will be made. Rather, these analyses will fuel further research by gathering information about clinician religiosities and motivations.

## **Methods**

### **Participants**

A total of 438 clinical trainees who are completing pre-doctoral internships associated with the Association of Psychology Postdoctoral and Internship Centers (APPIC) were contacted to participate in the study. A total of 53 responded to the survey, but 15 participants did not complete the measures, thus leaving a total sample size of 38. An email containing a link to the survey hosted on Qualtrics, a survey builder software tool, was sent to heads of the internship sites to disseminate to the pre-doctoral interns. Participants were offered the opportunity to be placed into a raffle system to earn a \$100 gift card for compensation for their participation in the study. The sample was primarily male ( $n = 31$ ), Caucasian ( $n = 29$ ), and had an average age of 28.92 years old ( $SD = 4.95$ ). Other specific demographic information is presented below in table A1.

### **Procedures**

The first independent variable in the present study used fictitious vignettes of a man who is being seen in a clinic due to possible problematic sexual behaviors. The vignettes contained descriptions of sexual behaviors that are high in frequency and wide in their type of expression. Also, this expression is relatively non-normal, but not inherently pathological. The vignettes only

varied in regard to the amount of distress that the client was experiencing regarding his sexual behaviors. Participants were assigned to read one of the two following vignettes:

The client is a 22-year-old, white, male-identified undergraduate student. He identified that he has had a **(distressing)** increase in his sexual activity in the last two years. He reported that he is recently separated, but that he enjoyed having a girlfriend. He ended his previous relationship because after dating for 5 months, he began to engage in sexual activity with other women in his classes. He felt it was 'right' to end it. He stated that he always uses a condom with all partners. He reports that although he liked having a girlfriend, all of his recent sexual encounters have been casual, and of little emotional value. He reports that he enjoys engaging in intercourse with many different women because he 'likes all kinds of sex.' When asked to elaborate, he reports that he likes sex play with masochistic themes the most, including BDSM and choking, but only if it is consensual to all people involved. He reports that he engages in sexual activity with a partner approximately 10-12 times a week, and has had sexual relations with 44 women in total. **(He reports that he would like to spend his time in other ways besides having intercourse or planning sexual activities, and that he feels he cannot go a day without sex.)**

The only modification between the two vignettes was the bolded statement. This bolded statement indicates distress with the behaviors listed, and should ideally be the main symptom that trainees home in on when labeling sexual addiction according to previously mentioned conceptualizations of sex addiction. The behaviors listed are all consensual and conducted in a way that is not pathological until the distress with the behavior exists. Participants randomly received one of the vignettes to read, and then completed other independent and dependent measures.

## Measures

Participants completed measures examining their religiosity and motivations. They completed a religion orientation question in which they reported their religious orientation (e.g., Christianity, Buddhism, Islam.). Quest religiosity was examined via the *Quest Scale* (Batson & Schoenrade, 1991). The Quest Scale is a 12-item, 9-point Likert-type scale with anchors at *strongly disagree* and *strongly agree*, and has shown relatively high reliability at  $\alpha = .81$ . The present study showed a reliability of  $\alpha = .88$ . An example question is: "It might be said that I

value my religious doubts and uncertainties.” High scores indicate high quest motivation, as the individual prefers ambiguity and often challenges their beliefs.

Intrinsic and extrinsic religiosity were measured via the *Religious Orientation Scale Revised* (Gorsuch & McPherson, 1989). This scale is a 14-item, 9-point Likert-type scale with anchors at *strongly disagree* and *strongly agree*. The scale consists of two subscales. One subscale of 8 items examined intrinsic religiosity, and the other subscale of 6 items examined extrinsic religiosity. An example intrinsic question is: “I enjoy reading about my religion,” and an example extrinsic question is: “I go to church because it helps me to make friends.” The reliability has been shown to be high for each subscale at  $\alpha = .82$ . This study found a reliability of  $\alpha = .86$  for the intrinsic subscale, and  $\alpha = .82$  for the extrinsic subscale.

Religious fundamentalism was measured via the *Religious Fundamentalism Scale* (Altemeyer & Hunsberger, 1992). This scale is 20 items with a 9-point Likert-type scale, with anchors at *strongly disagree* and *strongly agree*. The religious fundamentalism scale has shown high reliability at  $\alpha = .92$ . This study found a reliability of  $\alpha = .90$ . Participants also responded to the item “I believe in a God or a higher power.” This was used for exploratory purposes.

The dependent variables looking at sexual pathology were the same used in Hacker, Trepper, Wetchler and Fontaine (1995). Participants rated the sexual pathology of the client, the sexual addiction level of the client, and how likely the clinician would be to refer the client to a sex addiction therapist. All three measures were on a 5-point scale with anchors that are specific to each question, but they were consistent in that high scores indicated a high level of pathology/addiction/need to refer. Additionally, participants were asked “What factors in the vignette lead you to give the above rating?” for each question in order to examine what specific criteria they were pulling from the vignette in order to fuel their answer. Also, one question was

directly asked stating “Did the client report any distress about his symptoms?” This was answered by reporting *yes* or *no*.

## Results

### Sex Addiction Measures

Reliability analyses were conducted on the pathology measures. These three measures were shown to have high reliability with each other ( $\alpha = .85$ ). Additionally, a correlations show that the three dependent variables were all correlated with each other. That is, the level of pathology that the client has was significantly correlated with reports to the degree that the client can be described as a sex addict ( $r = .62, p < .01$ ) and the likelihood to refer the client to a sex addiction therapist ( $r = .69, p < .01$ ). Reports to the degree that the client can be described as a sex addict were also significantly correlated with the likelihood to refer the client to a sex addiction therapist ( $r = .66, p < .01$ ). Because the three dependent variables were significantly correlated with each other at a relatively high level, a multivariate analysis of variance (MANOVA) was conducted with vignette type (2 levels) as the fixed factor independent variable, and the three pathology questions as the dependent factor variables. Results indicated that there was no significant difference in the trainee clinicians’ rating of pathology in the vignette containing distress compared to the one without distress for all three pathology variables assessed,  $\lambda(3,34) = .09, p = .22$ . In order to be exhaustive and examine where the specific  $p$  values fell, further univariate analyses of variance (ANOVAs) were examined. These revealed that the level of sexual pathology of the client ( $F(1,36) = 3.58, p = .07$ ), the degree to which the client can be described as a sex addict ( $F(1,36) = .18, p = .68$ ), and the likelihood to recommend

that the client be referred to a sex addiction therapist for treatment ( $F(1,36) = .73, p = .40$ ) were all found to be non-significant. The means for each dependent variable based on vignette type are presented in table B1 and Figure B1 below.

### **Distress in the Vignette**

A chi-square analysis was conducted to examine if the trainee clinicians showed a significant difference from chance in their reported *yes* or *no* answers for deciding whether or not the client in the vignette reported distress. The analysis showed that trainee clinicians answered at a significantly different rate from chance depending on the vignette, and clinicians made significant errors when reporting if the client showed signs of distress ( $\chi^2 = 8.66, p = .01$ ). When the client did report distress, 38.9% of trainee clinicians ( $n = 7$ ) stated that the client did not report distress. Additionally, when no distress was present, 15% of trainee clinicians ( $n = 3$ ) reported that there was distress. Figure B2 below shows a graphical representation of the error reporting by trainee clinicians.

### **Religiosity Motivations**

Exploratory analyses were conducted to examine the relationship of scores on pathology measures and trainee clinicians' religiosity scores. The descriptive statistics of each of the religiosity measures are reported below in Table B2 and Figure B3. Quest religiosity was reported as the highest religious motivation ( $M = 5.49, SD = 1.59$ ).

Correlation analyses were conducted comparing scores on religiosity measures and the scores measuring sexual psychopathology based on each vignette type in order to examine the relationship between religiosity and pathology scores based on distressed. First, overall, intrinsic religiosity was found to be significantly correlated with religious fundamentalism ( $r = .86, p < .01$ ). No other religiosity motivations were significantly correlated with each other. This is

common within religiosity motivation literature. Second, as reported below in Table B4, none of the religiosity measures were shown to be significantly correlated with any of the dependent variable psychopathology measures. Table B4 presents the correlation scores between the religiosity scores and both the distressed and the non-distressed vignettes.

### Discussion

To begin, hypotheses 1, 2, and 3 were all supported by the analyses. There were no significant differences in ratings on all three of the pathology measures. In clinical reality, there *should* have been significant differences in the ratings. The vignettes presented differing levels of distress, and therefore differing levels of pathology. However, these data, along with the following qualitative analysis, can begin to suggest that trainee clinicians may have missed the distress or lack of distress presented in the vignette. For example, consider this participant's rating of (5) on the level that the client is described as a sex addict. A rating of (5) indicates that the client is "Definitely" a sex addict based on the vignette. This is the rating on a non-distressed vignette:

"Probably yes, if following the DSM-5's criteria of a gambling disorder (substitute gambling for sex). He has an increasing need to have sex with others or masturbate, has made repeated unsuccessful attempts to cut down, preoccupied with having sex, lost a relationship due to wanting sex, and these behaviors are not better explained by another mental disorder."

This answer has multiple inconsistencies that were found in other qualitative answers as well. First, the criteria for gambling disorder still requires distress and impairment, and is arguably different from sex addiction. Tangible items with monetary value are lost from gambling disorder, which is not the case in typical sex addiction. Second, the vignette does not mention anything about the client trying to cut down on their sexual behaviors, but the participant reported that this was within the vignette. Lastly, the idea of a monogamous



relationship being non-pathological and an open relationship being pathological is supported by the participant. The language that the participant used reflects that they view a breakup as a negative, but this could be a neutral or even positive thing for the client.

Participants were asked *During your education how much sexual health material do you feel that you have covered?* These results are shown in Figure B4 . As can be seen, 82.9% ( $n = 29$ ) of participants reported that they covered *a little to a moderate amount* of material on sexual mental health. Research literature shows that the sex negative views shown in western society translates into the classroom and practice with a lack of consideration of sexual mental health compared to other mental health pathology types (Russell, Gates, & Viggani, 2015). Training focuses on the importance of sexual health, but most do not receive actual training relating to these topics.

None of the religiosity measures showed any correlations to any of the pathology measures. This exploratory analysis showed that the prejudice and stigma towards out-groups shown in other research literature does not transfer over clinically. However, a major limitation to consider is the skew in the data brought on by a large non-believer (atheist / agnostic) population. As seen in figure B3, most participants identified higher in quest religiosity than the others. Additionally, 44.8% of the sample identified as atheist or agnostic. Quest believers showed no relation to increased prejudice in the research. This study suffered from a range restriction due to a lack of fundamentalists or intrinsic religiosity believers. Therefore, this research cannot be generalized to those groups. Research has shown that a large number of clinicians adhere to atheist or agnostic beliefs (Shafranske & Malony, 1990). Their research indicates that a majority of sampled clinical psychologists (29.8%) indicate *no religion* when

asked of their affiliation. This data, although it is not significant, may begin to show good news that clinicians are not holding potentially stigmatizing value systems.

These mindsets of over-pathologizing non-normal but non-problematic high sex frequencies are comparable to the over-pathologizing of paraphilic disorders within the field of psychology. The *DSM-5* has begun making solid distinctions between paraphilias, which are not pathological, and paraphilic disorders, which are pathological. The same concerns that were addressed by the creators of the criteria for the paraphilic disorders are currently very relevant to the sex addiction debate. Clinicians might benefit to focus on the distress or impairment when pathologizing behaviors, not the frequency or the type of behavior itself.

For example, a clinician wouldn't diagnose someone with Transvestic Fetishism because a man cross dresses every day and the clinician views that as abnormal. But, if the man is distressed by his want to cross dress or it is interfering with his life significantly, then it is diagnosable. The same idea should be taken for sex addiction. A client with a subjectively high number of partners or who watches pornography every day is not diagnosable, even if the clinician thinks this behavior is unhealthy or too much. The focus should always be on impairment or distress for these types of addictive behaviors. The *DSM-5* currently considers sexual mental health disorders in this way, and sex addiction should be considered in this way as well. Without a true definition of sex addiction, clients with healthy, non-normative sexual behaviors may be pathologized. This can lead to a waste of time, money, and possibly even be harmful for the client. As a field, we need to strive for accurate, well informed definitions of pathology in order to fuel evidence-based research and practice.

## **Limitations**

A few major limitations within this study have been touched on already, but warrant more elaboration. First, the lack of variability in religiosity motivation types could have significantly impacted the correlation analysis. Yet, due to the nature of the large non-believer identification by most clinicians, it is unlikely to find a large sample of fundamentalist. Second, the overall small sample size is a limitation. With only 38 participants, these results should only begin to fuel future research as they are in no way exhaustive. A total of 18 participants read the distressed vignette, and 20 read the non-distressed vignette. Also, these participants were only trainee psychology clinicians, and do not represent the entirety of those who treat problematic sexual behavior. For example, LMFTs, social workers, and many other counselors can see these clients.

Lastly, there was no specific manipulation check, other than the variable in question (distress), to examine if the participants actually read the vignette fully. Although we asked if there was distress in the vignette, a manipulation check should be added that is unrelated to the specific variable in question. Clinicians are paid and focus on pathologizing. They try to find a problem if one exists. This nature for clinicians may be a limitation in that trainee clinicians were *looking* for something to diagnose

## **Future Research and Conclusions**

Future research in this area should aim to reduce the limitations shown here by recruiting more participants and possibly including a video recorded session of a client rather than a vignette. This would overall increase the validity by allowing the clinician to view the session rather than read it, and could also give meaningful insight into the influence that attractiveness of the participant could have on the label of *sex addiction*. Additionally, future studies should

examine more value setting qualities other than just religiosity, including SES and other value factors.

In conclusion, this study sheds light on the possible existence of a decision making bias with trainee clinicians when considering potentially problematic sexual behaviors. Trainee clinicians appeared to not able to separate the lack of distress out from other behaviors such as high frequency or taboo sex play that might have caught their attention. Based on this data and with the limitations above in mind, religiosity does not appear to be a major contributor to the overall sexual health diagnostic capabilities of a clinician.

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# Appendix A

Table A1  
*Demographic information of the sample*

Categories	Sub-Categories	Frequency	Percent
Gender	Male	5	13.2
	Female	31	81.6
Sexual Orientation	Heterosexual	28	73.7
	Homosexual	2	5.3
	Bisexual	5	13.2
	Pansexual	1	2.6
Relationship Status	Single	10	27.8
	Casually Dating (no committed partner)	3	8.3
	Partnered (significant other, fiancé, etc.)	18	50
	Legal partnership (married, civil union)	5	13.9
Ethnicity	White	29	76.3
	Black	2	5.3
	Asian	2	5.3
	Biracial	2	5.3
	Hispanic/Latina	1	5.3
Religious Orientation	Christian	9	23.7
	Atheist	9	23.7
	Agnostic	8	21.1
	Catholic	7	18.4
	Jewish	3	7.9
	Buddhist	1	2.6
Type of Graduate Program	Counseling Ph.D.	9	23.7
	Clinical Ph.D.	25	65.8
	Other	2	5.3



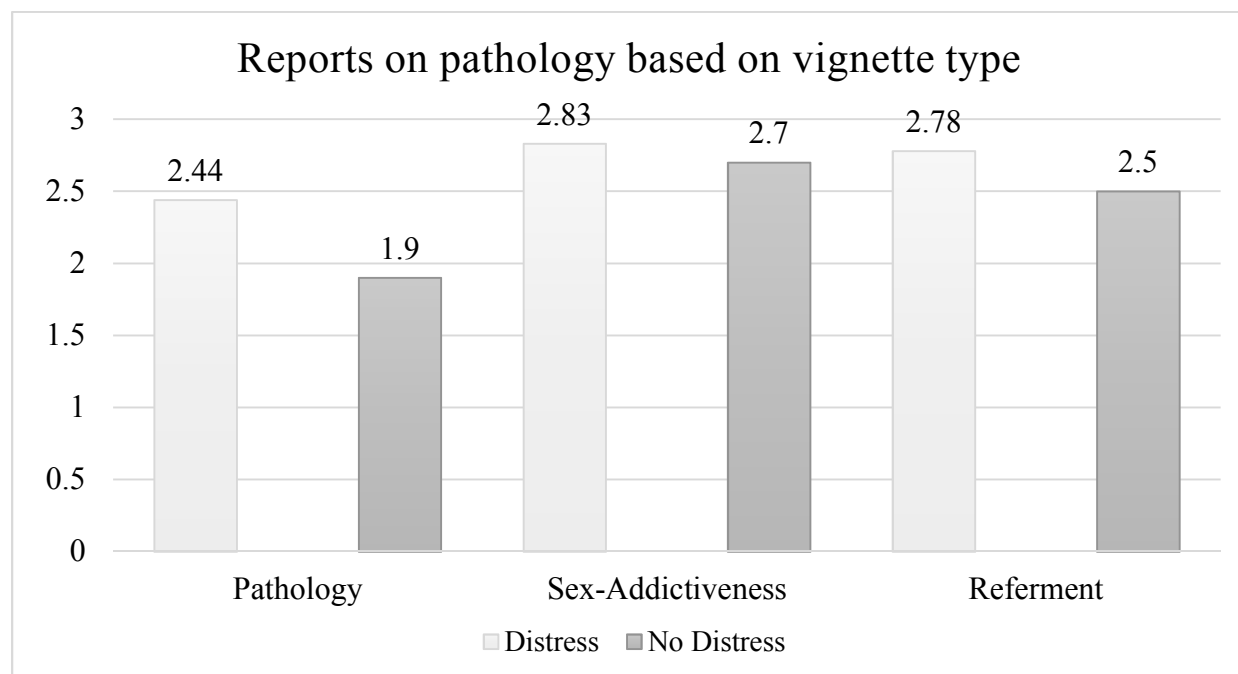
## Appendix B

Table B1

*Ratings of dependent variables based on vignette type*

Vignette Type	What is the level of sexual pathology presented by the client?	What is the degree to which the client is described as a sex addict?	Would you recommend that the client be referred to a sex addiction therapist?
Distress	$M = 2.44, s = .71$	$M = 2.83, s = .92$	$M = 2.78, s = 1.00$
No Distress	$M = 1.90, s = .20$	$M = 2.70, s = 1.03$	$M = 2.50, s = 1.00$

*Note:* no analyses showed significant differences between the groups



*Figure B1.* Reports of dependent variables based on vignette type

Table B2

*Descriptive statistics for scores of trainee clinicians on four religiosity measures*

Religiosity Type	Mean ( <i>M</i> )	Standard Deviation ( <i>s</i> )
Quest	5.49	1.59
Fundamentalism	2.67	1.53
Intrinsic	2.73	1.37
Extrinsic	2.81	1.02

Table B3

*Correlations between each of the religiosity and the pathology measures based on vignette type*

Distressed Vignette			
Measure	Level of Pathology	Sex-Addictiveness	Refer to Therapist
Quest	-.31	-.35	-.20
Fundamentalism	.17	.17	.21
Intrinsic	.07	.16	.15
Extrinsic	.05	.03	.16
Not Distressed Vignette			
Quest	.18	.07	-.03
Fundamentalism	-.10	.07	-.16
Intrinsic	-.16	-.01	-.20
Extrinsic	.10	.24	-.05

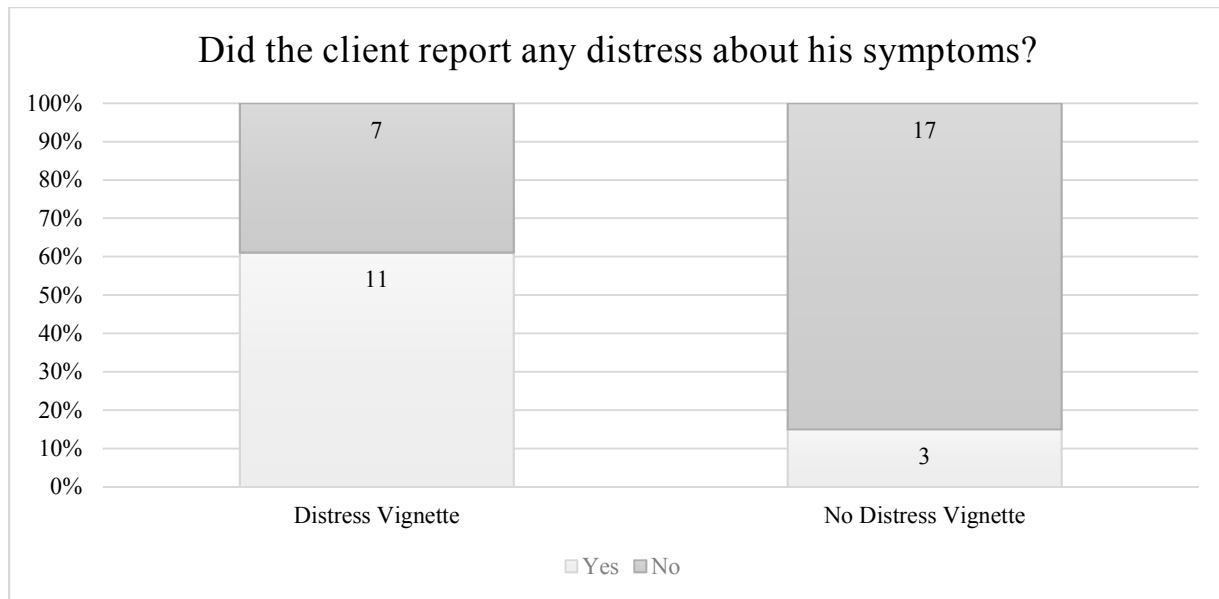


Figure B2. Reports by trainee clinicians of whether or not the vignette indicated distress based on each vignette type

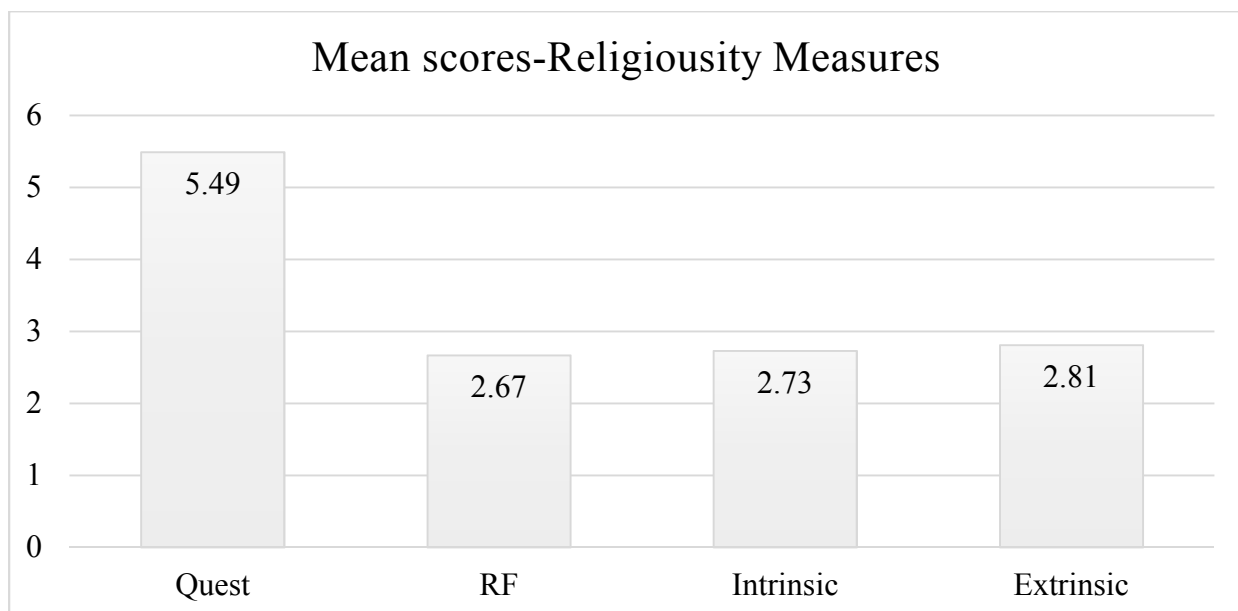
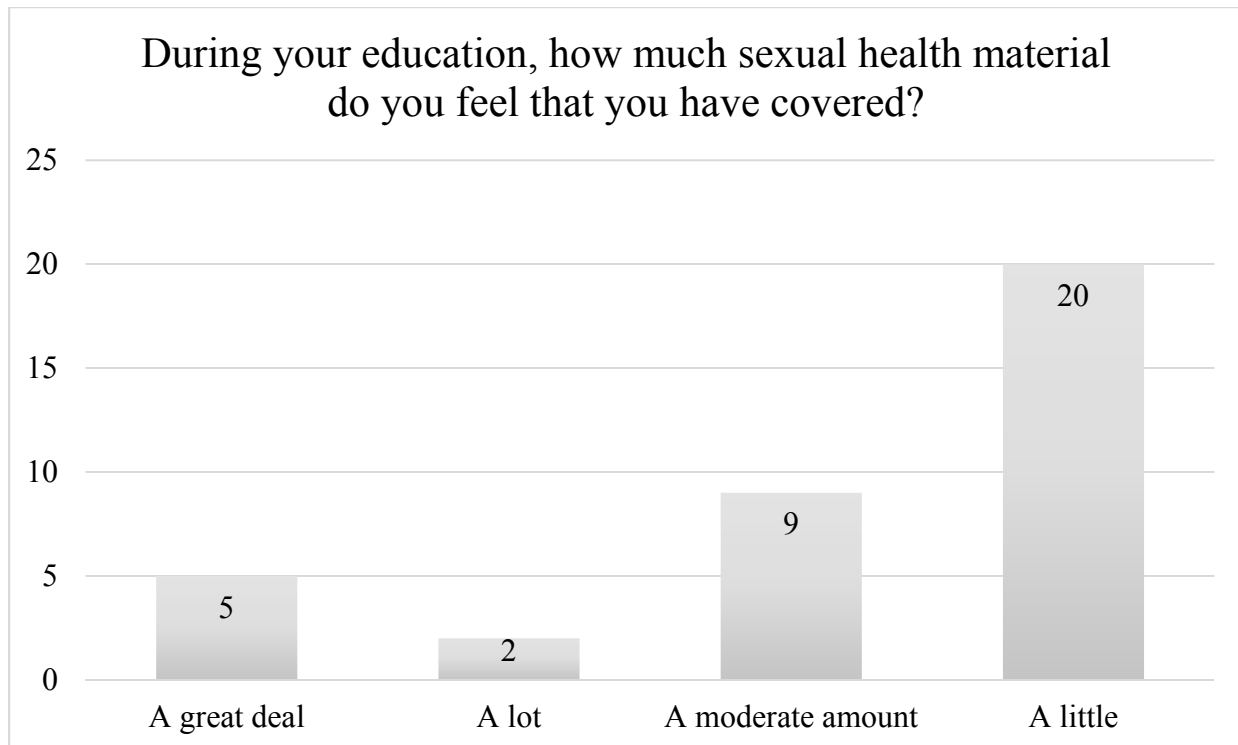


Figure B3. Reported mean religiosity motivation scores by trainee clinicians



*Figure B4.* Reported frequency of amount of sexual health education covered during training in graduate programs

